STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G496	A. BUILDING 00 B. WING	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the investigation of complaint #IN00158974. Complaint #IN00158974: SUBSTANTIATED, federal/state deficiencies related to the allegations cited at W104, W149, W157, W331. Dates of Survey: December 11, 12, and 18, 2014. Provider Number: 15G496 Facility Number: 001010 AIM Number: 100245040 Surveyor: Amber Bloss, QIDP The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed January 6, 2015 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	the facility. Based on record review and interview, the governing body failed to exercise general policy and operating direction over the facility to ensure client rights were ensured in regards to community outings with staff for an emancipated adult for 1 of 3 sampled clients (C). Findings include: The facility's "Community Outings" policy (undated) was reviewed on 12/12/14 at 1:55 PM and indicated the facility "actively works to ensure that all clients participating in the program are given the opportunity to participate in social, religious, and community group activities based on their interests and choices." The policy indicated "while our efforts are focused on outings for clients supported by current staff, management recognizes and supports the fact that positive, professional relationships may develop among clients and staff. When a staff separates employment from the agency, it can be difficult for the client, therefore we want to support the client in maintaining those relationships if he or she chooses. In order to do so, arrangements will be made with the Residential House Manager for the client to be accompanied by current staff and	W000104	**Toensure that all client rights are protected in regards to community outings,the following corrective action(s) will be implemented:** 1) Theinter-disciplinary team (IDT) met on 1/16/15 to discuss the policy regardingcommunity outings that is currently in place. It was decided by the team torevise the policy to ensure the rights of emancipated adults by evaluatingrequests for outings on an individual basis to determine if staffing isrequired when participating in outings with friends and former staff of theirchoosing. 2) TheVice President of Residential Services will revise the policy to reflect thesuggestion from the IDT team. Upon revision, the Vice President of ResidentialServices will submit the policy to the Human Rights Committee (HRC) and agencyBoard of Directors for review and approval. If approved, all Residential HouseManagers	01/23/2015

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	remain staffed during a desired community outing or activity with former staff members. This will ensure safety (and) well-being of the client at all times while in the community." On 12/12/14 at 2:10 PM during an interview, the Vice President of Residential Services (VP) stated the "Community Outing" policy was "not a new policy" but they had "just put it in writing." The VP stated they "put it in writing" to be sure "current staff" went with clients to outings to ensure their "safety." The VP indicated no "client rights are restricted" by the policy. On 12/17/14 at 4:10 PM during an interview, the Administrator indicated she didn't think the policy violated any client rights. The Administrator indicated clients could go on any community outing of their choosing with staff. When asked whether an emancipated client could go on outings with friends of their choice without staff, the Administrator indicated not every emancipated client could make those decisions. The Administrator indicated she understood the policy should include the procedure to ensure the rights of all clients, including those who have been emancipated to go on outings with people of their choosing.		and QIDP's within the Residential Services Department will be trainedon the policy. Record of training forms will be completed upon completion oftraining. 3) Toensure compliance, this policy will be reviewed annually to ensure that rightsof clients are protected and ensured.	

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	This federal tag relates to complaint s#IN00158974. 9-3-1(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement and/or develop written abuse/neglect polices to prevent client to client sexual abuse for 1 of 3 sampled clients (C) and 1 additional client (K) and to prevent a major medication administration error for 1 of 3 sampled clients (B). Findings include: 1) On 12/11/14 at 3:35 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/22/14 to 12/11/14. A BDDS report dated 12/2/14 indicated "a [Client K] came home from the [facility owned] workshop around 3:30pm on 12/1/2014 and was upset. Residential House manager and Residential Nurse asked	W000149	**Toensure that established agency policies and procedures for abuse, neglect, andmistreatment of clients are implemented and executed as written, the followingcorrective action(s) will be implemented:** 1) Allstaff located at 2333 Westdale Court (Westdale group home) will be re-trainedon the agency abuse and neglect policy. Record of training forms will becompleted upon completion of training. *Referto Appendix A for Record of Training form to be used*. 2) OnDecember 2, 2014 the workshop put the following	01/23/2015

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	[Client K] why he was upset. [Client K] ignored them at first. After a few minutes [Client K] told them that when he went to the bathroom at the workshop today that another consumer followed him into the bathroom." Client K indicated the client had "tried to put his penis in my butt. Client K indicated when he told Client C to stop, he did. The BDDS report indicated when Client C was interviewed and admitted to the sexual abuse allegation. The report indicated Client K was taken for a physical examination and a police report filed. The report indicated the facility "started an investigation immediately." The report indicated clients C and K were suspended from work pending investigation. The report indicated "protective measures in place at the [facility owned] workshop are: [Client C] will be escorted to and from all bathroom breaks by workshop staff, [Client C] will only use single stall bathrooms at [facility] workshop (which are located in the dock area and cafeteria), [Client C] and [Client K] are no longer in the same work area/same lunch breaks/or same break times, and [Client C] is in line of sight supervision at all times while at the workshop." On 12/12/14 at 11:25 AM during an interview, the day service Lead Qualified Intellectual Disabilities Professional		immediate measures in place forClient C: 1) client C will be escorted to and from the bathroom by staff; clientC will only use a single stall restroom which are located in the dock area andcafeteria; client C will remain in line of sight of his staff at all timeswhile at the workshop; and client C will be relocated to a different work area.	

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	(LQIDP) indicated the allegation of sexual abuse against Client C was substantiated. The LQIDP indicated Client C admitted to the allegation. The LQIDP indicated Client C stopped when Client K told him to stop. The LQIDP indicated Client C moved here from a state hospital and did not come with any information which indicated Client C had the potential to be a sexual predator. The LQIDP indicated Client C had a history of being a sexual abuse victim. The LQIDP indicated the safeguards put in place had continued and no further incident had occurred. The LQIDP indicated the allegation was substantiated and indicated a staff member had been terminated because the investigation found her to have been neglectful of her duties to supervise her area. The LQIDP indicated the staff responsible for supervising Client C's area had not been aware he went to the bathroom at the time of the incident. 2) On 12/11/14 at 3:35 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/22/14 to 12/11/14. A BDDS report dated 12/1/14 indicated "[Client B] returned on 11/30/14 and it was reported to the nurse that during her visit with family period of 11/27 - 11/30 she was given more units of Novolog (insulin)			

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	than the documented scale prescribed on the MAR (medication administration record). The family member whom assists [Client B] with her medication also attended [Client B]'s Doctor's visit when the doctor ordered that [Client B] will be on a sliding scale." The report indicated "it was explained and also documented on the MAR when to hold and contact the nurse if her glucose (blood sugar level) under 100. When documented by family member whom assists her that on 11/27 at 1p. (pm) glucose 78, on 11/28 at 4:42p glucose was 64, on 11/29 at 12:52p glucose was 79 and 5:32p glucose 89 also, on 11/30 at 12:54p glucose 74, 4:20p glucose 75. [Client B] was given 14 units each time that the glucose was under 100." The report indicated Client B's prescribed sliding scale of the Novolog was as follows: "10 units (Novolog) 100-150 (glucose level) 12 units 151-200 14 units 201-250 15 units 250 and >250 call nurse for blood sugar Glucose<100 hold and call the nurse." The report indicated "[Client B] was monitored by staff when she returned home with no adverse effects."			

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	On 12/12/14 at 11:54 PM, record review indicated Client B's diagnoses included, but were not limited to, mild intellectual disabilities and diabetes. Client B's MAR (medication administration record) indicated "Insulin Changes and Instructions" dated 10/22/14 which included the following steps: "1. Take blood sugar before each meal. 2. Administer 10 units of Novolog before each meal if Blood sugar is 150 or below. 3. Administer 12 units of Novolog before each meal blood sugar is 151-200. 4. Administer 14 units of Novolog before each meal if blood sugar is 201-250. 5. Administer 15 units of Novolog before each meal if blood sugar is greater than 250 and contact Residential Nurse. 6. Administer 30 units of Lantus at 9 p.m...". Client B's "Insulin Changes and Instructions" did not include the physician's order to hold the Novolog if Client B's blood sugar was under 100. Client B's MAR (medication administration record) indicated the accurate order of the sliding scale of insulin. On 12/12/14 at 1:35 PM during an interview, the QIDP (Qualified			

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	Intellectual Disabilities Professional) indicated Client B's relative had been trained on administering Client B's sliding scale Novolog but the QIDP stated she "thought a different person" administered Client B's Novolog that weekend. The QIDP indicated she didn't know about the incorrect Novolog instructions in Client B's MAR. On 12/12/14 at 3:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." This federal tag relates to complaint #IN00158974. 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.			

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	Based on record review and interview, the facility failed to ensure adequate corrective measures and safeguards were implemented in all settings after an allegation of client to client sexual abuse was substantiated for 1 of 3 sampled clients (B) and 1 additional client (K). Findings include: On 12/11/14 at 3:35 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/22/14 to 12/11/14. A BDDS report dated 12/2/14 indicated "a [Client K] came home from the [facility owned] workshop around 3:30pm on 12/1/2014 and was upset. Residential House manager and Residential Nurse asked [Client K] why he was upset. [Client K] ignored them at first. After a few minutes [Client K] told them that when he went to the bathroom at the workshop today that another consumer followed him into the bathroom." Client K indicated the client had "tried to put his penis in my [buttocks]." Client K indicated when he told Client B to stop, he did. The BDDS report indicated when Client B was interviewed and admitted to the sexual abuse allegation. The report indicated Client K was taken for a physical examination and a police report filed. The report indicated the facility "started an investigation immediately." The report indicated clients B and K were suspended from work pending investigation. The report indicated "protective measures in place at the [facility owned] workshop are: [Client B] will be escorted to and from all bathroom breaks by workshop staff, [Client B] will only use single stall bathrooms at [facility] workshop (which are located in the dock area and cafeteria), [Client B] and [Client K] are no longer in the same work area/same lunch breaks/or same break times, and [Client B] is in	W000157	**Toensure adequate safeguards are in place for Client B, the following correctiveaction(s) will be implemented:** 1) OnDecember 2, 2014 the workshop put the following immediate measures in place forClient C: 1) client C will be escorted to and from the bathroom by staff; clientC will only use a single stall restroom which are located in the dock area andcafeteria; client C will remain in line of sight of his staff at all timeswhile at the workshop; and client C will be relocated to a different work area. 2) Allworkshop staff were trained on the immediate procedures. Record of trainingforms were completed at the end of the training.	01/23/2015

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	line of sight supervision at all times while at the workshop." On 12/12/14 at 11:25 AM during an interview, the day service Lead Qualified Intellectual Disabilities Professional (LQIDP) indicated the allegation of sexual abuse against Client B was substantiated. The LQIDP indicated Client B admitted to the allegation. The LQIDP indicated Client B stopped when Client K told him to stop. The LQIDP indicated Client B moved here from a state hospital and did not come with any information which indicated Client B had the potential to be a sexual predator. The LQIDP indicated Client B had a history of being a sexual abuse victim. The LQIDP indicated the safeguards put in place had continued and no further incident had occurred. The LQIDP indicated the allegation was substantiated and indicated a staff member had been terminated because the investigation found her to have been neglectful of her duties to supervise her area. The LQIDP indicated the staff responsible for supervising Client B's area had not been aware he went to the bathroom at the time of the incident. On 12/12/14 at 2:29 PM during an interview, the residential QIDP indicated this was the first incident of Client B sexually abusing another client. The QIDP indicated Client B's BSP (behavior support plan) had been updated since the incident but had not been implemented because it required Human Rights Committee consent. The QIDP indicated no new safeguards were added to the residential setting because they have not had any incidents there. The QIDP indicated Client B was not being monitored more carefully because it was already a group home with 24 hour supervision. This federal tag relates to complaint			

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	#IN00158974. 9-3-2(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing staff failed to ensure a client's protocol and instructions for sliding scale insulin was written as prescribed by a physician for 1 of 3 sampled clients (B). Findings include: On 12/11/14 at 3:35 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/22/14 to 12/11/14 were reviewed. A BDDS report dated 12/1/14 indicated "[Client B] returned on 11/30/14 and it was reported to the nurse that during her visit with family period of 11/27 - 11/30 (2014) she was given more units of Novolog (insulin) than the documented scale prescribed on the MAR (medication administration record). The family member whom assists [Client B] with her medication also attended [Client B]'s	W000331	**Toensure proper execution of physician's orders for Client B, the followingcorrective action(s) will be implemented:** 1) TheResidential Nurse will contact the prescribing physician for clarification ofinstructions for sliding scale insulin. Upon clarification, the ResidentialNurse will create a plan for the sliding scale insulin and staff located at2333 Westdale Court will be trained on the plan. Record of training forms willbe completed upon completion of the training. 2) Inthe event that Client B will leave to visit friend or relatives for overnightand/or weekend trips, the Residential Nurse will ensure that all family andfriends that could potentially administer medications to Client B will bethoroughly trained on the sliding scale procedures. Signatures will be obtainedto indicate verification of training. ***a. Howwill the facility monitor to ensure compliance?"*** All Residential Nurses will berequired to develop systems in	02/01/2015

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	Doctor's visit when the doctor ordered that [Client B] will be on a sliding scale." The report indicated "it was explained and also documented on the MAR when to hold and contact the nurse if her glucose (blood sugar level) under 100. When documented by family member whom assists her (was) that on 11/27 at 1p. (pm) glucose 78, on 11/28 at 4:42p glucose was 64, on 11/29 at 12:52p glucose was 79 and 5:32p glucose 89 also, on 11/30 at 12:54p glucose 74, 4:20p glucose 75. [Client B] was given 14 units each time that the glucose was under 100." The report indicated Client B's prescribed sliding scale of the Novolog was as follows: "10 units (Novolog) 100-150 (glucose level) 12 units 151-200 14 units 201-250 15 units 250 and >250 call nurse for blood sugar Glucose<100 hold and call the nurse." The report indicated "[Client B] was monitored by staff when she returned home with no adverse effects." On 12/12/14 at 11:54 PM, record review indicated Client B's diagnoses included, but were not limited to, mild intellectual disabilities and diabetes. Client B's MAR		which they a) conduct weekly reviews of allmedication records for all clients residing in the home b) observe staff on aroutinely basis to ensure that all medications are administered according tophysician's orders and agency policy. In the event of a medication error, theResidential Nurse will immediately review all medication records for allclients residing in the home, not just those that are affected, to ensure thatno other medication errors have occurred, that staff fully comprehend andunderstand directives for medication administration as stated on the MAR(medication administration record), and that medications are being administeredaccording to physician's orders and agency policy.	

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	(medication administration record) indicated "Insulin Changes and Instructions" dated 10/22/14 which included the following steps: "1. Take blood sugar before each meal. 2. Administer 10 units of Novolog before each meal if Blood Sugar is 150 or below. 3. Administer 12 units of Novolog before each meal blood sugar is 151-200. 4. Administer 14 units of Novolog before each meal if blood sugar is 201-250. 5. Administer 15 units of Novolog before each meal if blood sugar is greater than 250 and contact Residential Nurse. 6. Administer 30 units of Lantus at 9 p.m...". Client B's "Insulin Changes and Instructions" did not include the physician's order to hold the Novolog if Client B's blood sugar was under 100. Client B's MAR (medication administration record) indicated the accurate order of the sliding scale of insulin. On 12/12/14 at 1:35 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client B's relative had been trained on administering Client B's sliding scale Novolog but the QIDP			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G496	A. BUILDING 00 B. WING	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	stated she "thought a different person" administered Client B's Novolog that weekend. The QIDP indicated Client B's sliding scale insulin protocol should have been written as the order was prescribed by the physician. The QIDP indicated the facility's nursing staff developed the insulin protocol and left off the part of the order which called for the Novolog to be held if Client B's glucose level was under 100. This federal tag relates to complaint #IN00158974. 9-3-6(a)			